Home Care Aide Certification Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
Home Care Aide Credentialing
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Home Care Aide Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Certification Requirements

Applicants for home care aide certification are required to have a fingerprint-based background check. The applicant must first contact the Department of Social and Health Services (DSHS) to get a "Fingerprint-Based Background Originating Agency's Case Number (OCA #)." Your application with the Department of Health (DOH) will be considered deficient until an OCA # is provided.

Note:

- An applicant can have several OCA #s, but DOH will only use one or the most recent fingerprint-based background OCA # given.
- An exempt applicant will still need a fingerprint-based background OCA #.
- An applicant who provides services that do not meet the definition of long-term care worker may not have an OCA #.

  If you do not have an OCA # be sure to complete section 3 of the application form.

Requirements for those who must apply for Home Care Aide Certification

An applicant who must be certified as a home care aide includes:

- Individual providers of home care services. An individual provider is defined as someone who is reimbursed by the state;
- Direct care employees of home care agencies;
- Providers of home care services to persons with developmental disabilities under Title 71 RCW, paid by DSHS;
- All direct care workers in state licensed boarding homes, assisted living facilities, and adult family homes;
- Respite care providers;
- Community residential service providers;
- Any other direct care worker providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.

Long-term care workers do not include:

- Persons employed by the following facilities or agencies: nursing homes subject to chapter **18.51 RCW**, hospitals or other acute care settings, residential habilitation centers under chapter **71A.20 RCW**, facilities certified under 42 CFR, Part 483, hospice agencies subject to chapter **70.127 RCW**, adult day care centers, and adult day health care centers, or persons who are not paid by the state or by a private agency or facility licensed by the state to provide personal care services.

Certification Requirements (Continued)

You may apply for state certification by completing the following requirements:

1. Fill out and submit the certification application and fee;
2. Complete a 75 hour basic training course approved by DSHS before taking the examination;
3. Submit a copy of the DSHS 75 hour training certificate of completion;

   Note: Please remember to keep your original DSHS training certificate of completion for your records.
4. Fill out and submit the examination application, fee, and the DSHS 75 hour training certificate of completion to Prometric. For more information on the examination, go to **Examination Information** within this document. Applicants must successfully pass the home care aide written and skills certification examination;
5. Submit any Out-of-state Credential Verification form(s) completed by each state(s) in which you hold or have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State Department of Health.

Effective January 7, 2012, the law allows long-term care workers to work for a maximum of 150 days while you are in the process of applying for certification. You may provide care before receiving certification while you are in the process of completing the following conditions:

1. Fill out and submit a certification application and fee within three days of your hire date;
2. Complete the training required by **RCW 74.39A.073(4)(a) and (b)**.

Training Required:

A long-term care worker must successfully complete all of the training within 120 calendar days of the date of hire as a long-term care worker. A long-term care worker who has not completed all of the training requirements within 120 calendar days is no longer eligible to provide care and you must stop working until certification as a home care aide has been granted.

Information for Long-Term Care Workers
Exempt from Certification

Exemptions:

There are three categories of exemptions. Please see below to determine if you belong in any of these categories. If you are exempt and still want to obtain a home care aide certification, please follow the instructions that go along with your particular exemption.

A. Long-term care workers are exempt from certification and training and can work without a home care aide certification if one the following applies:

- You already hold an active health care credential as an advanced registered nurse practitioner, registered nurse, licensed practical nurse, nursing assistant certified, certified counselor, certified adviser, speech-language pathologist assistant, audiologist, occupational therapist, or physical therapy assistant;

Certification Requirements (Continued)

- You are employed by a Medicare certified home health agency and have met the requirements of **42 CFR, Part 484.36**;
- You have special education training and have an endorsement granted by the Office of Superintendent of Public Instruction;
- Supported living provider (unless you are also licensed as a boarding home or adult family home provider).

Requirements for long-term care workers above who are exempt from certification and training:

You may apply for state certification by completing the following requirements:

1. Fill out and submit the certification application and fee;
2. Fill out and submit the examination application and fee to Prometric. For more information on the examination, go to **Examination Information** within this document. Pass the home care aide written and skills certification examination administered by Prometric;
3. Complete four hours of AIDS education and training;
4. Submit any Out-of-state Credential Verification form(s) completed by each state in which you hold or have held a credential. The state will complete its portion of the verification form and will mail it directly to Washington State Department of Health.

B. Another exemption from both certification and training includes the following:

You have been employed as a long-term care worker at some point during the calendar year 2011, or between January 1, 2012 and January 6, 2012, and you have successfully completed all the training requirements in effect as of the date of hire.

Note: This exemption expires if you have not provided care for over three years.

Requirements for Long-Term Care Workers—Employed during 2011

You may apply for state certification by completing the following requirements:

1. Fill out and submit the certification application and fee;
2. Submit the proof of employment which may include a letter or the attached Employment Verification form from the employer that hired you or for whom you worked during 2011, and or between January 1, 2012 and January 6, 2012;
3. Submit proof of completion of the training requirements that were in place on your date of hire with that employer (see attached form);
4. Fill out and submit the examination application and fee to Prometric. For more information on the examination, go to **Examination Information** within this document. Pass the home care aide written and skills certification examination;
5. Complete four hours of AIDS education and training;
6. Submit any Out-of-state Credential Verification form(s) completed by each state in which you hold or have held a credential. The state will complete its portion of the verification form and will mail it directly to Washington State Department of Health.

Certification Requirements (Continued)

C. Long-term care workers are exempt from certification, but not from training include:

- You are an individual provider caring only for your biological, step, or adoptive child or parent.
- You are an individual provider hired prior to June 30, 2014, who provides twenty hours or less of care for one person in any calendar month.

Requirements for workers who are exempt from certification but not from training:

You may apply for state certification by completing the following requirements:

1. Fill out and submit the certification application and fee;
2. Complete a 75 hour basic training course approved by DSHS before taking the examination;
3. Submit a copy of the DSHS 75 hour training certificate of completion;

   Note: Please remember to keep your original DSHS training certificate of completion for your records.

4. Fill out and submit the examination application, fee, and 75 hours of training certificate of completion to Prometric. For more information on the examination, go to **Examination Information** within this document. Pass the home care aide written and skills certification examination;
5. Complete four hours of AIDS education and training;
6. Submit any Out-of-state Credential Verification form(s) completed by each state in which you hold or have held a credential. The state will complete its portion of the verification form and will mail it directly to Washington State Department of Health.

Examination Information:

You need to apply directly to Prometric to take the examination.

Your application to Prometric requires a Credential Number from the Department of Health. Even though your credential will not have been issued, you will receive a credential number while your home care aide certification application is pending. You can find your number at the following web site:

https://fortress.wa.gov/doh/providercredentialsearch/SearchCriteria.aspx

Search by Your Name, use Home Care Aide as the credential type, use your last name and first name, and click on “Search.”

The contact information for Prometric is as follows:

Prometric
1260 Energy Lane
St Paul, MN 55108
Phone: 800.324.4689
Web site: **http://www.prometric.com/wadoh.htm**

Prometric will notify you of the date, time, and place of the examination. Prometric will notify both you and the Department of Health of your examination results.

Certification Requirements (Continued)

Other Information:

You will be mailed a letter regarding the deficiencies of your application if the application is incomplete.

- The application is considered incomplete if requested information is left blank Write N/A or place a line through section instead of leaving blank.
- The initial certification will expire on your birthday. If the initial certification is issued within 90 days of your birthday, your renewal will be due on your birthday the following year.
- Certifications must be renewed every year not later than your birthday as provided in chapter **246-12 WAC, Part 2**. A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is considered late.
- Information regarding the home care aid program is available on our **Web site**.

Continuing Education Requirements:

Home care aides must demonstrate completion of twelve hours of continuing education per year.

- The required continuing education must be obtained during the period between renewals. The required continuing education must be approved by DSHS. Continuing education is subject to the provisions of chapter **246-12 WAC, Part 7**.
- Verification of completion of the continuing education requirement is due upon renewal. If the first renewal period is less than a full year from the date of certification, no continuing education will be due for the first renewal period.

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Washington State Department of Health

Application Instructions Checklist

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms to the Department of Health.

☐ **Application Fee**. This fee is **non-refundable**. You can check the online **fee page** for current fees.

☐ **Fingerprint-based Background OCA #:** You may have requested background checks from the Department of Social and Health Services in the past. If so, you may have received prior OCA #s. The Department of Health will only accept the **"most recent"** Fingerprint-based Background OCA #.

☐ **1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send you any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known by any other names. If you have a name change after obtaining a credential, you must notify the Department of Health in writing. You must include legal proof of this change. See **WAC 246-12-300**.

☐ **2: Personal Data Questions:**
All applicants must answer the same personal data questions on the application. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide a complete and accurate explanation. You must submit the appropriate documentation as noted in the personal data questions. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 refers to misdemeanors, gross misdemeanors and felonies. You do not have to answer “yes” if you have been cited for traffic infractions. You can get copies of your court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority in which convictions may have occurred.

☐ **3: Type of Services Provided:**
Long term care workers—check all that apply:

- ☐ Home care services
- ☐ Adult family home
- ☐ Community residential services
- ☐ Assisted living facility
- ☐ State licensed boarding home
- ☐ Respite care
- ☐ Direct care employee of home care agencies
- ☐ Any other direct care worker providing home or community based services to the elderly or persons with functional or developmental disabilities

Services that do not meet the definition of long term care—check all that apply:

- ☐ Nursing homes
- ☐ Hospitals
- ☐ Residential habilitation centers
- ☐ Hospice agencies
- ☐ Adult day care centers
- ☐ Adult day health care centers
- ☐ Medicare certified facilities
- ☐ Currently employed
- ☐ Any other care worker who is not paid by the state or by a private agency, or facility licensed by the state

Other Providers—check all that apply:

- ☐ An individual provider caring only for his or her biological, step, or adoptive child or parent.
- ☐ A person hired as an individual provider who provides twenty hours or less of care for one person in any calendar month.

☐ **4: Training and Education:**
List in date order, most recent to later, your training and education. Attach additional completed pages if you need more space. We require certification of training be sent directly from your training program to the Department of Health.

☐ **5: Work Experience:**
List in date order, most recent to later, your professional work experience.

☐ **6: Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if active. Attach additional completed pages if you need more space. Verification of credentials is required on the form provided.

Note: Many states charge a verification/certification processing fee. Please contact them first to prevent a delay in the review of your application.

☐ **7: AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in **WAC 246-12-270**.

☐ **8: Living Within or Outside of Washington State Attestation:**
You must attest to one of the following:

- Lived at anytime for the last two years within Washington State, **OR**
- Lived at anytime within the last two years outside Washington State.

☐ **9: Applicant's Attestation:**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **http://www.doh.wa.gov/hsqa/professions/military/** and include supporting documentation with your application.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0299100001

Home Care Aide Certification Application

Fingerprint-based Background OCA #: _____
(If you do not have a Fingerprint-based background OCA #, be sure to complete section 3 of the application form.)

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name:	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record:

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

Certification # _____ Date Issued _____

2. Personal Data Questions

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?	☐	☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Type of Services Provided

Long term care workers—check all that apply:

- ☐ Home care services
- ☐ Adult family home
- ☐ Community residential services
- ☐ Assisted living facility
- ☐ Respite care
- ☐ State licensed boarding home
- ☐ Direct care employee of home care agency
- ☐ Any other direct care worker providing home or community based services to the elderly or persons with functional or developmental disabilities.

Services that do not meet the definition of long term care—check all that apply:

- ☐ Nursing homes
- ☐ Hospitals
- ☐ Residential habilitation centers
- ☐ Hospice agencies
- ☐ Adult day care centers
- ☐ Adult day health care centers
- ☐ Medicare certified facilities
- ☐ Currently employed
- ☐ Any other care worker who is not paid by the state or by a private agency, or facility licensed by the state.

Other Providers—check all that apply:

- ☐ An individual provider caring only for his or her biological, step, or adoptive child or parent.
- ☐ A person hired as an individual provider who provides twenty hours or less of care for one person in any calendar month.

4. Training and Education

List in date order, most recent to later, your training and education. Attach additional completed pages if you need more space.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

5. Work Experience

List in date order, most recent to later, your work experience. Attach additional completed pages if you need more space.

Name and Location of Institution	From (mm/dd/yy)	To (mm/dd/yy)	Type of Experience or Speciality

6. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

State	License/Certification/Registration Type	License/Certification/Registration		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grand Fathered

7. Aids Education and Training Attestation

☐ School curriculum

☐ Employer/Other

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

8. Living Within or Outside of Washington State Attestation

Please check the box that applies:

☐ I certify I have lived for the last two years within Washington State.

☐ I certify I have lived within the last two years outside of Washington State.

Applicant's Initials	Date

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Print name of applicant clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

by:_____
(Original signature of applicant)

Washington State Department of Health
Home Care Aide Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Employment Verification Form

(to be completed by employer)

I certify that the individual listed below **was** working during 2011, and or between January 1, 2012 and January 6, 2012. I understand that my signature on this form will allow this individual to apply for the home care aide certification.

Last Name of individual hired:	
First Name:	Middle Name/Initial:
Beginning Date of Employment:	Last Date of Employment:
Job Title and Description:	
Training requirements on the date individual was hired:	

Note: Attach to this form **EITHER** proof of training, which can be Certificate of Completion, **OR** Employment Verification that training was completed.

Name of Employer (print) Title (print)

Signature of Employer

Please send completed form to the above address.

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Washington State Department of Health
Home Care Aide Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a health care provider. Instruct them to return the form directly to the address listed below. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name:	Last	First	Middle
Mailing Address			
City		State	Zip Code
Any other names used:			
Type of health care license, certification, or registration:			
License, Certification, or Registration Number		Date Issued	

Have the licensing agency return this completed form to the address listed above.

If you have any questions, please call 360.236.4700.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
Name of examination:		
☐ Other Examination	Date:	Score:
Name of examination:		
Is credential current: ☐ Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no," please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No		

(SEAL)

Signature: _____

Title: _____

Date: _____

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... RCW 18.130

Administrative Procedure Act ..... RCW 34.05

Administrative procedures and requirements..... WAC 246-12

Home Care Aide Law.....RCW 18.88B

Home Care Aide Rules..... WAC 246-980

On-line

AIDS Training Resources .....Reference Page

Department of Social and Health Services,
Aging and Disability Services
Administration ..... http://www.adsa.dshs.wa.gov/professional/training

Home Care Aide Program .....Web Page

Prometric ..... http://www.prometric.com/default.htm

List-Serv

To receive emails regarding important home care aide information,
please join our interested parties at..... List-Serv